		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0029132

Facility Name: COMMUNITY CARE CENTER

Address: 4314 WABASH AVE. (Number) CHICAGO (City) 60653 (Zip Code)

County: COOK

Telephone Number: (847) 674-5795 **Fax #** (847) 674-5794

IDPA ID Number: 36-3327511

Date of Initial License for Current Owners: 11/26/84

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) GENERAL PARTNER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	145	Skilled (SNF)	145	52,925	1
2		Skilled Pediatric (SNF/PED)			2
3	59	Intermediate (ICF)	59	21,535	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	204	TOTALS	204	74,460	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			4,042	4,042	8
9	SNF/PED					9
10	ICF	67,963	19	303	68,285	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	67,963	19	4,345	72,327	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.14%

D. How many bed-hold days during this year were paid by Public Aid? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/ 26 /84

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/26/84 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 30 and days of care provided 4,042

Medicare Intermediary ADMINISTAR OF ILLINOIS

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	230,902	26,117	15,820	272,839		272,839		272,839			1
2	Food Purchase		286,905		286,905		286,905	(1,207)	285,698			2
3	Housekeeping	128,823	23,950		152,773		152,773		152,773			3
4	Laundry	111,711	18,271	801	130,783		130,783		130,783			4
5	Heat and Other Utilities			119,837	119,837		119,837	457	120,294			5
6	Maintenance	103,751	21,434	58,884	184,069		184,069	3,458	187,527			6
7	Other (specify):* Scavenger,Security			25,051	25,051		25,051	140	25,191			7
8	TOTAL General Services	575,187	376,677	220,393	1,172,257		1,172,257	2,848	1,175,105			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,746,152	93,041	16,979	1,856,172		1,856,172		1,856,172			10
10a	Therapy	72,019		3,538	75,557		75,557		75,557			10a
11	Activities		7,957	2,414	10,371		10,371		10,371			11
12	Social Services	163,382		2,219	165,601		165,601		165,601			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,981,553	100,998	31,150	2,113,701		2,113,701		2,113,701			16
	C. General Administration											
17	Administrative	76,070		600,000	676,070		676,070	(572,915)	103,155			17
18	Directors Fees											18
19	Professional Services			63,620	63,620		63,620	10,041	73,661			19
20	Dues, Fees, Subscriptions & Promotions			20,464	20,464		20,464	(6,590)	13,874			20
21	Clerical & General Office Expenses	150,313	19,719	72,780	242,812		242,812	(40,051)	202,761			21
22	Employee Benefits & Payroll Taxes			381,859	381,859		381,859		381,859			22
23	Inservice Training & Education							85	85			23
24	Travel and Seminar			1,236	1,236		1,236	90	1,326			24
25	Other Admin. Staff Transportation			4,187	4,187		4,187	664	4,851			25
26	Insurance-Prop.Liab.Malpractice			165,479	165,479		165,479	2,603	168,082			26
27	Other (specify):*			1,294,427	1,294,427		1,294,427	(1,285,069)	9,358			27
28	TOTAL General Administration	226,383	19,719	2,604,052	2,850,154		2,850,154	(1,891,142)	959,012			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,783,123	497,394	2,855,595	6,136,112		6,136,112	(1,888,294)	4,247,818			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number COMMUNITY CARE CENTER #0029132 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			95,651	95,651		95,651	65,224	160,875			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,455	10,455		10,455	377,634	388,089			32
33	Real Estate Taxes							164,652	164,652			33
34	Rent-Facility & Grounds			776,937	776,937		776,937	(776,937)				34
35	Rent-Equipment & Vehicles			21,499	21,499		21,499	4,655	26,154			35
36	Other (specify):*							6,552	6,552			36
37	**TOTAL Ownership**			904,542	904,542		904,542	(158,220)	746,322			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		96,253	211,838	308,091		308,091		308,091			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			111,690	111,690		111,690		111,690			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		96,253	323,528	419,781		419,781		419,781			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,783,123	593,647	4,083,665	7,460,435		7,460,435	(2,046,514)	5,413,921			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(36,044)	30		9
10	Interest and Other Investment Income	(1,388)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,207)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(675)	21		18
19	Entertainment		20		19
20	Contributions	(7,243)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,294,427)	27		24
25	Fund Raising, Advertising and Promotional	(758)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(341,439)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,683,181)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(363,333)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (363,333)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,046,514)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

COMMUNITY CARE CENTER

ID# 0029132

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2	STAFF DEVELOPMENT	(8,312)	21	2
3	MARKETING SALARY	(33,127)	21	3
4	YOSEF DAVIS MANAGEMENT FEES	(300,000)	17	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(341,439)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number COMMUNITY CARE CENTER **#** 0029132 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,207)	0	0	0	0	0	0	0	0	0	0	(1,207)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	457	0	0	0	0	0	0	0	457	5
6	Maintenance	0	0	2,667	791	0	0	0	0	0	0	0	3,458	6
7	Other (specify):*	0	0	140	0	0	0	0	0	0	0	0	140	7
8	**TOTAL General Services**	(1,207)	0	2,807	1,248	0	0	0	0	0	0	0	2,848	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(300,000)	(283,214)	10,299	0	0	0	0	0	0	0	0	(572,915)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	299	9,455	287	0	0	0	0	0	0	0	10,041	19
20	Fees, Subscriptions & Promotions	(8,001)	0	1,411	0	0	0	0	0	0	0	0	(6,590)	20
21	Clerical & General Office Expenses	(42,114)	9,446	(7,526)	143	0	0	0	0	0	0	0	(40,051)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	85	0	0	0	0	0	0	0	0	85	23
24	Travel and Seminar	0	0	90	0	0	0	0	0	0	0	0	90	24
25	Other Admin. Staff Transportation	0	527	137	0	0	0	0	0	0	0	0	664	25
26	Insurance-Prop.Liab.Malpractice	0	1,145	1,343	115	0	0	0	0	0	0	0	2,603	26
27	Other (specify):*	(1,294,427)	2,895	6,463	0	0	0	0	0	0	0	0	(1,285,069)	27
28	**TOTAL General Administration**	(1,644,542)	(268,902)	21,757	545	0	0	0	0	0	0	0	(1,891,142)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,645,749)	(268,902)	24,564	1,793	0	0	0	0	0	0	0	(1,888,294)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(36,044)	379	507	970	99,412	0	0	0	0	0	0	65,224	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,388)	0	0	2,141	376,881	0	0	0	0	0	0	377,634	32
33	Real Estate Taxes	0	0	0	1,263	163,389	0	0	0	0	0	0	164,652	33
34	Rent-Facility & Grounds	0	0	0	(15,657)	(761,280)	0	0	0	0	0	0	(776,937)	34
35	Rent-Equipment & Vehicles	0	1,334	3,090	231	0	0	0	0	0	0	0	4,655	35
36	Other (specify):*	0	0	0	0	6,552	0	0	0	0	0	0	6,552	36
37	TOTAL Ownership	(37,432)	1,713	3,597	(11,052)	(115,046)	0	0	0	0	0	0	(158,220)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,683,181)	(267,189)	28,161	(9,259)	(115,046)	0	0	0	0	0	0	(2,046,514)	45

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
YOSEF DAVIS	50	SCHEDULE ATTACHED		EKS MGMT.	LINCOLNWOOD	BOOKKEEPING
MORRIS ESFORMES	50			EMI ENTERPRISES	LINCOLNWOOD	MGMT CONSULT
				IME REALTY	LINCOLNWOOD	HOME OFFICE
				RSM		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 300,000	EMI ENTERPRISES		$	$ (300,000)	1
2	V								2
3	V								3
4	V	17	OFFICERS SALARY				16,786	16,786	4
5	V	19	ACCOUNTING FEES				299	299	5
6	V	21	OFFICE EXPENSE				9,446	9,446	6
7	V	25	TRANSPORTATION				527	527	7
8	V	26	INSURANCE				1,145	1,145	8
9	V	27	EMPLOYEE BENEFITS				2,895	2,895	9
10	V	30	DEPRECIATION				379	379	10
11	V	35	AUTO LEASE				1,334	1,334	11
12	V								12
13	V								13
14	Total			$ 300,000			$ 32,811	$ * (267,189)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	BOOKKEEPING FEES	$ 41,000	EKS MANAGEMENT, INC.		$	$ (41,000)	15
16	V								16
17	V								17
18	V	6	PAINTERS SALARIES				2,667	2,667	18
19	V	7	SCAVENGER				140	140	19
20	V	17	CFO SALARY				10,299	10,299	20
21	V	19	PROFESSIONAL FEES				9,455	9,455	21
22	V	20	WANT ADS				1,411	1,411	22
23	V	21	OFFICE EXPENSE				33,474	33,474	23
24	V	23	SEMINARS				85	85	24
25	V	24	IN STATE LODGING /MEALS				90	90	25
26	V	25	TRANSPORTATION				137	137	26
27	V	26	INSURANCE				1,343	1,343	27
28	V	27	EMPLOYEE BENEFITS				6,463	6,463	28
29	V	30	DEPRECIATION				507	507	29
30	V	35	EQUIPMENT RENTAL				3,090	3,090	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 41,000			$ 69,161	$ * 28,161	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	OFFICE RENT	$ 15,657	IME REALTY CORP.		$	$ (15,657)	15
16	V								16
17	V								17
18	V	5	UTILITIES				457	457	18
19	V	6	REPAIRS				791	791	19
20	V	19	PROFESSIONAL FEES				287	287	20
21	V	21	OFFICE EXPENSE				143	143	21
22	V	26	INSURANCE				115	115	22
23	V	30	DEPRECIATION				970	970	23
24	V	32	INTEREST				2,141	2,141	24
25	V	33	RE TAX				1,263	1,263	25
26	V	35	STORAGE FEES				231	231	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 15,657			$ 6,398	$ * (9,259)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 761,280	RSM NURSING ASSOCIATES	100.00%	$	$ (761,280)	15
16	V	30	DEPRECIATION				99,412	99,412	16
17	V	32	INTEREST				376,881	376,881	17
18	V	33	REAL ESTATE TAXES				163,389	163,389	18
19	V	36	AMORT.-DEFERRED MORT COST				6,552	6,552	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 761,280			$ 646,234	$ * (115,046)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	MORRIS ESFORMES	OFFICER	Administrative		SEE ATTACHED			SALARY	16,786	17-8	2
3											3
4											4
5	AVRUM WEINFELD	C F O						SALARY	10,299	17-8	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 27,085		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICER SALARY	PATIENT DAYS	797,100	13	$ 185,000	$ 185,000	72,327	$ 16,786	1
2	19	ACCOUNTING FEES	PATIENT DAYS	797,100	13	3,299		72,327	299	2
3	21	OFFICE EXPENSE	PATIENT DAYS	797,100	13	104,106	76,720	72,327	9,446	3
4	25	TRANSPORTATION	PATIENT DAYS	797,100	13	5,805		72,327	527	4
5	26	INSURANCE	PATIENT DAYS	797,100	13	12,620		72,327	1,145	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	797,100	13	31,900		72,327	2,895	6
7	30	DEPRECIATION	PATIENT DAYS	797,100	13	4,180		72,327	379	7
8	35	AUTO LEASE	PATIENT DAYS	797,100	13	14,702		72,327	1,334	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 361,612	$ 261,720		$ 32,811	25

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MANAGEMENT
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	PAINTERS SALARY	PATIENT DAYS	797,100	13	$ 29,397	$	72,327	$ 2,667	1
2	7	SCAVENGER	PATIENT DAYS	797,100	13	1,544		72,327	140	2
3	17	CFO SALARY	PATIENT DAYS	797,100	13	113,499	113,499	72,327	10,299	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	797,100	13	104,205		72,327	9,455	4
5	20	WANT ADS	PATIENT DAYS	797,100	13	15,548		72,327	1,411	5
6	21	OFFICE EXPENSE	PATIENT DAYS	797,100	13	368,910	256,444	72,327	33,474	6
7	23	SEMINARS	PATIENT DAYS	797,100	13	940		72,327	85	7
8	24	IN STATE LODGING / MEALS	PATIENT DAYS	797,100	13	994		72,327	90	8
9	25	TRANSPORTATION	PATIENT DAYS	797,100	13	1,506		72,327	137	9
10	26	INSURANCE	PATIENT DAYS	797,100	13	14,803		72,327	1,343	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	797,100	13	71,229		72,327	6,463	11
12	30	DEPRECIATION	PATIENT DAYS	797,100	13	5,592		72,327	507	12
13	35	EQUIPMENT RENT	PATIENT DAYS	797,100	13	34,056		72,327	3,090	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 762,223	$ 369,943		$ 69,161	25

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY CORP.
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	268,762	13	$ 7,839	$	15,657	$ 457	1
2	6	REPAIRS / MAINT	INCOME	268,762	13	13,572		15,657	791	2
3	19	PROFESSIONAL FEES	INCOME	268,762	13	4,925		15,657	287	3
4	21	OFFICE EXPENSE	INCOME	268,762	13	2,448		15,657	143	4
5	26	INSURANCE	INCOME	268,762	13	1,978		15,657	115	5
6	30	DEPRECIATION	INCOME	268,762	13	16,647		15,657	970	6
7	32	INTEREST	INCOME	268,762	13	36,747		15,657	2,141	7
8	33	RE TAX	INCOME	268,762	13	21,685		15,657	1,263	8
9	35	STORAGE FEES	INCOME	268,762	13	3,962		15,657	231	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 109,803	$		$ 6,398	25

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: RSM NURSING ASSOCIATES
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT	1	1	$ 99,412	$	1	$ 99,412	1
2	32	INTEREST	DIRECT	1	1	376,881		1	376,881	2
3	33	REAL ESTATE TAXES	DIRECT	1	1	163,389		1	163,389	3
4	36	AMORT.-DEFERR. MORT. COS	DIRECT	1	1	6,552		1	6,552	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 646,234	$		$ 646,234	25

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY ALLOCA.						$	$			$	1
2	RSM(DAVIS)	X			$5,000.00	9/1/94	465,000	207,053	11/01/06	0.0800	18,390	2
3	EMES LIMITED PARTNERSHIP		X		$975.00	9/1/94	127,440	8,096	12/01/06	0.0800	3,607	3
4												4
5	LASALLE BANK(RSM)		X	MORTGAGE	$35,284.00	11/30/01	4,838,255	4,772,088	11/30/08	0.0735	354,854	5
	Working Capital											
6	LASALLE BANK		X	WORKING CAPITAL	INTEREST	REVOLV		300,000	REVOLV	PRIME +	10,455	6
7												7
8	RELATED PARTY										2,141	8
9	TOTAL Facility Related				$41,259.00		$ 5,430,695	$ 5,287,237			$ 389,447	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,430,695	$ 5,287,237			$ 389,447	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 158,584	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 160,987	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,403	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 160,986	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 163,389	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	168,364	8
	1998	171,353	9
	1999	170,203	10
	2000	158,584	11
	2001	160,987	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME COMMUNITY CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0029132

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	20-03-300-021-0000	NURSING HOME	$ 3,665.70	$ 3,665.70
2.	20-03-300-022-0000	NURSING HOME	$ 38,299.93	$ 38,299.93
3.	20-03-300-023-0000	NURSING HOME	$ 39,088.28	$ 39,088.28
4.	20-03-300-024-0000	NURSING HOME	$ 38,516.54	$ 38,516.54
5.	20-03-300-025-0000	NURSING HOME	$ 37,729.80	$ 37,729.80
6.	20-03-300-026-0000	NURSING HOME	$ 3,686.47	$ 3,686.47
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 160,986.72	$ 160,986.72

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 80,088 B. General Construction Type: Exterior FRAME Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME			$ 98,640	1
2					2
3	TOTALS			$ 98,640	3

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	204				$ 2,393,321	$ 61,367	39	$ 61,367	$	$ 510,857	4
5											5
6											6
7											7
8	IME ALLOCATION					795		795			8
	Improvement Type**										
9	VARIOUS			1985	57,320					57,320	9
10	VARIOUS			1986	12,387	826	15	826		10,955	10
11	VARIOUS			1987	4,819	153	31.5	153		3,212	11
12	VARIOUS			1988	948	30	31.5	30		573	12
13	VARIOUS			1989	3,644	116	31.5	116		1,996	13
14	VARIOUS			1992	6,146	195	31.5	195		2,484	14
15	VARIOUS			1993	17,589	558	31.5	558		5,939	15
16	UNDERGROUND PLUMBING			1994	1,607	41	39	41		360	16
17	DOORS			1994	630	16	39	16		131	17
18	NURSING STATION			1995	3,000	77	39	77		613	18
19	INSTALLED BATH TUB			1995	8,606	221	39	221		1,699	19
20	ROOF REPAIR			1995	14,900	382	39	382		2,913	20
21	FLOOR COVERING			1995	9,876	253	39	253		1,980	21
22	ROOF WORK			1996	2,200	56	39	56		367	22
23	INSTALL NEW PUMP UNIT, CAR DOOR FOR ELEVATOR			1997	18,215	467	39	467		2,565	23
24	FURNISH & INSTALL BASE, VINYL - 3RD FLOOR			1997	38,100	977	39	977		5,333	24
25	INSTALL NEW MODIFIED ROOF SYSTEM			1997	5,150	132	39	132		1,544	25
26	CHAIN LINK FENCE			1998	3,723	248	15	248		1,023	26
27	FRONT ENTRY DOOR			1998	1,793	46	39	46		213	27
28	GREASE TRAP & TILES			1998	4,300	110	39	110		481	28
29	FIREDAMPERS WITH SLEEVES			1998	4,279	110	39	110		463	29
30	SEAL UP CRACKS AROUND THE BUILDING			1998	3,900	100	39	100		421	30
31	PLUMBING			1999	7,200	185	39	185		640	31
32	CEMENT AND ASPHALT WORK			1999	5,900	151	39	151		510	32
33	WALL PAPER			2000	5,155	1,262	7	1,262		3,261	33
34	BOILER			2000	4,537	165	27.5	165		337	34
35	AUDIT RCI GENERATOR			1986	8,181					8,181	35
36	AUDIT SUMP PUMP			1986	414					414	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	AUDIT EXHAUST FAN	1986	$ 1,132	$		$	$	$ 1,132	37
38	AUDIT CABINETS	1987	9,462					9,462	38
39	NURSING STATION	2001	24,600	894	27.5	894		1,378	39
40	DOORS	2001	6,867	250	27.5	250		385	40
41	TILING	2001	12,958	4,147	5	4,147		6,739	41
42	CARPETING	2001	6,344	2,030	5	2,030		3,299	42
43	TILING	2002	5,400	106	27.5	106		106	43
44	CARPETING	2002	1,438	632	5	288	(344)	288	44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,716,041	$ 77,098		$ 76,754	$ (344)	$ 649,574	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 466,724	$ 51,796	$ 38,173	$ (13,623)	10 YRS	$ 259,281	71
72	Current Year Purchases	56,608	24,907	2,830	(22,077)	10 YRS	2,830	72
73	Fully Depreciated Assets	182,719					182,719	73
74	EKS,IME,EMI,RSM ALLOC.		39,107	39,107			323,383	74
75	TOTALS	$ 706,051	$ 115,810	$ 80,110	$ (35,700)		$ 768,213	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,520,732	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 192,908	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 156,864	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (36,044)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,417,787	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 8,557 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY VAN	01 CHEVY VAN	$ 699.00	$ 9,805	17
18	ADMINISTRATIVE	00 BUICK REGAL	440.00	3,137	18
19					19
20					20
21	TOTAL		$ 1,139.00	$ 12,942	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-8	hrs	$		$ 90,779	$		$ 90,779	1
2	Licensed Speech and Language Development Therapist	39-8	hrs			152			152	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-8	hrs			105,547			105,547	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescrpts				80,622		80,622	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39-8					30,991		30,991	13
14	TOTAL			$		$ 196,478	$ 111,613		$ 308,091	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number COMMUNITY CARE CENTER **#** 0029132 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 203,185	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,188,962		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	61,326		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	310,737		8
9	Other(specify): TAX DEPOSIT	24,000		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,788,210	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	303,531		15
16	Equipment, at Historical Cost	733,645		16
17	Accumulated Depreciation (book methods)	(733,867)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 303,309	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,091,519	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 408,954	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	300,000		29
30	Accrued Salaries Payable	147,003		30
31	Accrued Taxes Payable (excluding real estate taxes)	34,075		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,116		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO R.S.M.	1,086,695		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,977,843	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,977,843	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,113,676	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,091,519	$	48

***(See instructions.)**

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,492,073	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,492,073	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	191,603	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(570,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (378,397)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,113,676	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,480,666	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,480,666	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	147,076	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 147,076	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,388	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,388	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSION	2,450	28
28a	ADJ PRIOR YEAR EXPENSES	20,458	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 22,908	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,652,038	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,172,257	31
32	Health Care	2,113,701	32
33	General Administration	2,850,154	33
	B. Capital Expense		
34	Ownership	904,542	34
	C. Ancillary Expense		
35	Special Cost Centers	308,091	35
36	Provider Participation Fee	111,690	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,460,435	40
41	**Income before Income Taxes (line 30 minus line 40)****	191,603	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 191,603	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.** TAX RETURN CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,987	3,987	$ 87,310	$ 21.90	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,316	6,772	137,398	20.29	3
4	Licensed Practical Nurses	38,110	40,190	676,196	16.82	4
5	Nurse Aides & Orderlies	87,193	93,081	727,990	7.82	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,078	7,277	72,019	9.90	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	18,752	20,936	163,382	7.80	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	29,237	31,743	230,902	7.27	15
16	Dishwashers					16
17	Maintenance Workers	8,939	9,518	103,751	10.90	17
18	Housekeepers	20,374	22,229	128,823	5.80	18
19	Laundry	14,108	15,487	111,711	7.21	19
20	Administrator	2,080	3,419	76,070	22.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,759	16,231	150,313	9.26	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	6,002	6,234	73,219	11.75	31
32	Other Health Care(specify)					32
33	Other(specify) Qual Assurance	2,080	2,154	44,039	20.45	33
34	TOTAL (lines 1 - 33)	259,015	279,258	$ 2,783,123 *	$ 9.97	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 15,820	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	3,044	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	8,718	10-3	39
40	Physical Therapy Consultant	L	1,490	10a-3	40
41	Occupational Therapy Consultant	Y	1,388	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,414	11-3	44
45	Social Service Consultant	E	2,219	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 41,093		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DENISE MARTIN	ADMIN	0	$ 76,070
	ASST ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 76,070

B. Administrative - Other

Description	Amount
EMI ENTERPRISES	$ 300,000
J. DAVIS	300,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 600,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		63,620
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 63,620

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 83,616
Unemployment Compensation Insurance	33,618
FICA Taxes	213,412
Employee Health Insurance	42,289
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	500
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	8,424
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 381,859

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	686
Health Care Worker Background Check	2,440
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	758
TRUST/FRANCHISE/CONTRIB/ETC	7,243
LICENSES & PERMITS	4,166
DUES & SUBSCRIPTIONS	5,171
MGMT CO ALLOCATION	1,411
TRUST/FRANCHISE/CONTRIB/ETC	(7,243)
Less: Public Relations Expense	(0)
Non-allowable advertising	(758)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,874

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT FEE ALLOC	90
Seminar Expense	
	1,236
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,326

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINTING/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILLINOIS COUNCIL LONG TERM CARE 5009**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **111,690**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: COMMUNITY CARE CENTER **#0029132** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	15,820	
	REPAIRS & MAINTENANCE		0	
			0	15,820
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		801	
			0	801
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		40,752	
	ELECTRICITY		57,528	
	WATER		19,498	
	CABLE TV - LOBBY		2,059	
			0	119,837
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		8,369	
	PAINTING & DECORATING		1,742	
	BUILDING REPAIRS		8,195	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		20,346	
	ELEVATOR MAINTENANCE & REPAIR		8,597	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		5,578	
	FIRE SERVICE		6,057	
			0	
			0	
			0	58,884
7	**OTHER**			
	SCAVENGER		16,646	
	SECURITY SERVICE		8,405	25,051
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,000	6,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		(200)	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	2,117	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	3,044	
	PHARMACY CONSULTANT	XVIII B 39-2	8,718	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL		3,300	
				16,979
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	660	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	1,490	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	1,388	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	3,538
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,414	
			0	2,414
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	2,219	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	2,219
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number COMMUNITY CARE CENTER **#0029132** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	600,000	600,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	18,070	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	45,550	
			0	63,620
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	758	
	EMPLOYEE WANT ADS	XIX F	686	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	5,171	
	LICENSES & PERMITS	XIX F	4,166	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	7,243	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	2,440	20,464
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		2,509	
	OUTSIDE CLERICAL SERVICES		41,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	675	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		20,284	
	MESSENGER SERVICE		0	
	STAFF DEVELOPMENT		8,312	72,780

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	213,412	
	UNEMPLOYMENT COMPENSATION	XIX D	33,618	
	WORKERS COMPENSATION INSURANC	XIX D	83,616	
	HOSPITALIZATION INSURANCE	XIX D	42,289	
	EMPLOYEE BENEFITS - OTHER	XIX D	500	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	8,424	381,859
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	1,236	
	TRAVEL	XIX G	0	
			0	
			0	1,236
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		4,187	4,187
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		165,479	165,479
27	**OTHER**			
	BAD DEBTS	VI 24	1,294,427	
			0	1,294,427

GRAND TOTAL COLUMN 3 OTHER 2,855,595

COMMUNITY CARE CENTER
EMPLOYEE MEAL RECLASSIFICATION
12/31/2002

TOTAL FOOD PURCHASE	286,905	PATIENT MEALS	216981
LESS SALES TAX	(1,207)	ADD EMPLOYEE MEALS	0
NET FOOD	285,698	TOTAL MEALS/YEAR	216981
TOTAL PATIENT CENSUS	72,327	NET FOOD	285698
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	216981
TOTAL PATIENT MEALS	216981	COST PER MEAL	1.32
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		